

11–26% of patients, respectively (table 1). Treatment modification consisted mainly of nodal boosting (83%), followed by extended-field radiotherapy (62%) and debulking (12%). Sensitivity analysis slightly increased the estimated undertreatment rate from 9–11% to 12%, whereas the overtreatment rate was reduced from 11–26% to 5%.

Abstract #814 Table 1 Treatment modification, overtreatment and undertreatment rates in advanced-stage cervical cancer patients with FDG-positive lymph nodes.

		Primary analysis	Sensitivity analysis
Positive predictive value	%	70-87	94
Prevalence of nodal metastases	%	45	90
Treatment modification	n	379/435	379/435
	%	87	87
Undertreatment	n	39-49	53
	%	9-11	12
Overtreatment	n	49-114	23
	%	11-26	5

Conclusion PET-CT had a significant impact on nodal treatment plans with modification rates of up to 87%, mainly consisting of nodal boosting. Therefore, the estimated undertreatment rate is relatively low (9–11%), while overtreatment may affect up to one quarter of patients (11–26%). The higher the likelihood of nodal metastases, the more patients will benefit from these treatment plan modifications.

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#819 PELVIC EXENTERATION: OUTCOMES OF SEVEN PATIENTS IN A TERTIARY SETTING

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Introduction/Background Pelvic exenteration is an ultraradical surgery performed for selected cases in genital tumors. When free surgical margin is achieved, up to 40% 5 year survival is possible in select cases. . We present our 7 year experience in a tertiary hospital setting.

Methodology All patients undergoing pelvic exenteration in Akdemiz University Department of Gynecology was retrospectively evaluated.

Results Totally 7 patients were included. The median age was 68 years. All patients was diagnosed with recurrent or locally advanced cervical cancer. One patient underwent for palliative purposes. All but one was infraleatory exenteration. In all patients at least one complication was experienced. All patients was referred to ICU post-operatively. Major complication was seen in four patients (57%). Four patients required re-operation (57%). In two patients surgical margin was positive and received salvage chemotherapy. Median hospital stay was 29 days. One patients diagnosed with pulmonary emboli. There was two abdominal wound breakdown and two perineal wound dehiscence. Two patients underwent ostomy revision. One patient experienced aorto-jejunal fistula 15 months after

exenteration. She was re-operated but succumbed to the disease. Two patients are alive without any evidence of disease. Progression free survival was 18 months, five patient died of disease (one because of Porto-jejunal fistula, one from sepsis 3 months after the surgery who had been operated for palliative purposes).

Conclusion Complications after pelvic exenteration are common. Re-operations and re-admission are also frequently seen. In highly selected patients, when free margins are achieved, long term survival is possible.

Disclosures None

#820 SURVIVAL ASSOCIATED WITH THE USE OF ONE-STEP NUCLEIC ACID AMPLIFICATION (OSNA) TO DETECT SLN METASTASIS IN CERVICAL CANCER

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Introduction/Background Sentinel lymph node (SLN) biopsy is part of surgical treatment of apparent early-stage cervical cancer. SLN is routinely analyzed by ultrastaging and immunohistochemistry. Recently, one-step nucleic acid amplification (OSNA) method has been demonstrated to be an accurate tool to detect SLN metastases in cervical cancer with the advantage of a rapid standardized technique with no sampling bias. Nevertheless, oncological safety of OSNA method in cervical cancer has not been previously explored. The aim of this study was to assess the disease-free survival of patients undergoing SLN analyzed by OSNA compared with ultrastaging.

Methodology Single-center, retrospective, cohort study. Patients undergoing SLN mapping (\pm pelvic lymphadenectomy) and primary surgery for apparent early-stage cervical cancer between 05/2017 and 01/2021 were included. SLN was analyzed entirely with OSNA or with ultrastaging. Patients with SLN mapping failure, with SLN analyzed alternatively/serially with OSNA and ultrastaging and undergoing neo-adjuvant therapy were excluded. Appropriate statistical tests were used.

Results One-hundred and fifty-seven patients were included, 50 (31.8%) in the OSNA group and 107 (68.2%) in the ultrastaging group. Patients' characteristics are showed in table 1. The only significant difference between the two groups was the incidence of lymph node metastasis (28.0% versus 10.3% in OSNA versus ultrastaging group, respectively; $p=0.009$). A trend toward higher incidence of micrometastases detection in OSNA group was noted (table 1). Median follow up time was 41 months (95%CI:37.9–42.2). 5-year DFS in patients undergoing OSNA versus ultrastaging was 87.0% versus 91.0% ($p=0.809$). No difference in the incidence of lymph node recurrence between the two groups was noted (OSNA 20.0% versus ultrastaging 18.2%, $p=0.931$).